

Circular was probably founded by James Yearsley, who also created the *Medical Directory*. With this amalgamation of the two journals in 1866 the publication was transferred to London, and A. A. Tindall owned and published the journal for no less than sixty-five years, up to his death, at the age of 91, eight years ago.

Mr. Cecil Wakeley, the present Editor, responded to the toast. He said that when he first became acquainted with the *Medical Press and Circular* he was fortunate enough to come under the influence of Dr. Harry Campbell, who looked on his work with the journal as a hobby, and exemplified the fact that a hobby might be a relaxation from and yet a stimulus to work at one and the same time. The policy of the journal had always been, and would always be, to give the medical practitioner information which was important in everyday practice. The medical profession was really a great body of research, clinical research was the most important of all, and it was through the medical journals that the knowledge gained by research was disseminated throughout the profession.

Sir Humphry Rolleston, in proposing the toast of "Medical Journalism," said that editors of medical journals did all they could to instruct the members of the profession, to keep them up to date, and to provide them with the material on which they could form their own opinions. Editors were a modest race and shunned the limelight, but they had great experience and wide knowledge of human nature, as was shown by their dealings with their contributors. He divided medical editors into two classes, the first being the "whole-time Olympians," such as the late Sir Squire Sprigge and the late Sir Dawson Williams, but with these he mentioned the late Charles Louis Taylor, assistant editor of the *British Medical Journal* for many years under Dawson Williams—a wonderful medical journalist, though he held no medical qualification. But the larger number of medical editors, like Mr. Wakeley himself, were "part-time Olympians," and to them also the profession was indebted.

Two responses were made to the toast, the first by Mr. Eric Pearce Gould, who referred to the considerable contribution which the professional journals made to the general equipment of the profession, and the other by Mr. R. F. West, great-great-grandson of Dr. Arthur Jacob, who suggested that the time had come for the writing of a history of medical journalism. He said that Dr. R. J. Rowlette, in his recent history of the *Medical Press and Circular*, had lifted one corner of the curtain, and on behalf of those connected with the publication of the journal he thanked him for the care and industry which he had devoted to this little memorial. The history in its way was also the history of the medical profession, from a state of chaos so far as professional organization was concerned to the present happier times.

JAN EVANGEL PURKINJE

Born in 1787 and dying in 1869, Purkyně's name connotes little more than "the cells of Purkinje" to most British histologists and neurologists. A Bohemian by birth, he was destined for the priesthood, drifted into medicine at Prague, was appointed professor of physiology at Breslau in 1822, and was called to Prague as professor of physiology in 1849. Here he was long known for his friendly personality, and published many papers in German periodicals, but wrote no book. The whole of his works are now being issued in six quarto volumes. The first volume was published in 1918; the second volume, which has just appeared,¹ contains his contributions, written in German, on the physiology of men, beasts, and plants, with some other contributions written between 1820 and 1845. This second volume contains a portrait of Purkinje as a frontispiece, and a summary of its contents, but there is no index. From the librarian's point of view it is unsatisfactory, because it is issued in a paper cover and the sheets are not stitched. It must therefore be cased before it can be issued to readers.

¹ *Sebrané Spisy (Opera Omnia)*. Volume II. By Jan Evangel Purkyně. (Pp. 179; no price given.) Prague: Purkynova Společnost.

NEUROSES IN WAR-TIME

LECTURES AT THE TAVISTOCK CLINIC

The last two lectures of the course on "Neuroses in War-time" at the Tavistock Clinic were delivered on January 26, when Dr. G. W. B. JAMES spoke on "Physical and Psychotic Syndromes" and Dr. J. R. REES on "Emergency Treatment of Neurotic States."

PHYSICAL AND PSYCHOTIC SYNDROMES

Dr. James opened by saying that the neuroses of war could be considered in two ways: first, by looking back at the experience of the last European war, and, secondly, by endeavouring to anticipate ways in which a future war might differ from the last. His own experience was obtained during three and a half years in France, first as a field ambulance officer, later as battalion officer, and for a month or two at the base looking after the so-called shell-shocked cases. In the early part of the war few physicians and certainly hardly any members of the public had any close familiarity with psychotic or psychoneurotic syndromes, but by Christmas, 1914, a dozen or more officers and a few hundred men of the regular army had been evacuated with queer symptoms labelled neurasthenia, shock, exhaustion, or concussion. Very few neuroses occurred during quiet trench warfare, but they ran into thousands after set battles. It was said that a new war disease had appeared, and that "of course" the doctors could do nothing for it, and also that it appeared to be due to the rapid growth of high-explosive artillery.

Four Categories

He divided these casualties into four groups, which he named colloquially the "blown-ups," the "wind-ups," the "fed-ups," and the "signed-ups," meaning by the last the cases of classical psychosis. The "blown-ups" were cases in which there had been serious injury as the result of shell explosion or burial in dug-outs or buildings. The majority were badly shaken, showing a condition comparable in civil life to that following a motor smash. The "wind-ups" comprised the multiple hysterical manifestations, loosely summarized as shell-shock cases proper. The "fed-up" cases occurred among the very best type of men, some of whom had been in every "show" of the battalion in which they served. They had had very infrequent periods of rest, and eventually they became neurasthenic. Leaving the "signed-ups" out of account, the "blown-ups" represented 25 per cent. of the cases and the "wind-ups" and "fed-ups" 75 per cent.

There was also a very large group of cases of the "fed-up" category which never appeared in the official figures, but showed symptoms probably common to all who served in the field—namely, a mild exhaustion, usually put right by rest. The symptoms ranged from mere staleness to a profound condition of "fed-up-ness," often accompanied by severe emotional depression. This depression led to a deliberate seeking of what the soldiers called a "blighty"—namely, a wound which would take them home—and sometimes the wish took the form of a self-inflicted injury or a deeper wish for death, which ended in suicide.

The "blown-ups" showed light shock or graver injuries affecting the brain, with or without involvement of the skull, and the psychotic symptoms which followed such an experience. The "wind-ups" showed conversion hysteria and the anxiety state, and the "fed-ups" neurasthenia and the exhaustion syndrome.

Head Injuries

In a more detailed examination of these different categories, Dr. James said that in the "blown-up" cases, where the skull was obviously fractured and the patient deeply unconscious with laceration and exposure of brain tissue, immediate evacuation was always carried out if at all possible. A good many mistakes were made over the

prognosis of these cases of head injury, and he remembered that he was himself almost reprimanded because, after writing a gloomy letter to the relatives, he learned that the patient had arrived in London in excellent condition. It was his impression that as a class these "blown-ups" were not taken seriously enough. The remote effects of mild concussion were much underestimated. He could recall more than one instance of a man who had been taken out of a smashed dug-out or building, and whom he believed to be hysterical, having certainly no focal signs of injury, who died between the aid post and the field ambulance station after being sent down the line. Cases in this group often showed hysterical and anxiety symptoms at a later stage, but it was the organic conditions to which he wished to refer. The experience of being blown up or knocked down by shell fire appeared sometimes to be the starting point of epilepsy. It might be that service conditions lighted up a constitutional tendency to epilepsy, though there were no figures to support that thesis. Among the "blown-ups" he saw more than once the precipitation of symptoms of general paralysis, and another organic disease apparently following a "blown-up" episode was disseminated sclerosis.

The "wind-up" group showed many physical symptoms, including blindness, deaf-mutism, and paraplegia. A vicious circle was sometimes set up in which the vegetative nervous system played a very large part. A quite trivial episode might precipitate a severe condition in men of the "wind-up" class, especially if the episode was unexpected. He knew many men of this type who went through a battle quite successfully and broke down hysterically when an unexpected explosion occurred on a quiet sector.

The "fed-up" cases seemed to begin invariably with symptoms of exhaustion or fatigue. It had to be remembered that the soldier had very little relief from exposure to weather and to shell-fire, and his drill and preparation were extremely monotonous. He became stale, lost interest in his work, and sometimes got into unmerited trouble with his officers.

True Psychosis

There was no evidence to show (Dr. James continued) that insanity owing to the stress of war was more common in the soldier than in the civilian. In the great war the evidence was rather the other way. He related one or two experiences of his own showing the possible effect of war in precipitating psychosis. In one case a man under 40, a regular soldier who had been subject to manic-depressive psychosis before the war, went through the whole period of war service without a relapse but had a severe attack of depression shortly after the armistice, during which he shot himself.

He quoted some figures given him by Dr. Prideaux of the Ministry of Pensions disproving the popular view that the strain of war increased the incidence of insanity among the troops. The average number of new admissions annually to mental hospitals of men of military age—that is, 20 to 44—was approximately 80 per 100,000 of the population. The average strength of the Army during the war was 3,000,000, so that on that basis there should have been a yearly admission rate due to psychosis of 2,400, which would have corresponded to the civilian average. Actually the total number for whose care the Ministry of Pensions accepted liability—and this represented 95 per cent. roughly of the total considered—was just under 5,000 for the whole of the five war years. This suggested that the incidence of psychosis among soldiers in the great war was considerably lower—more than 50 per cent. lower—than would have been expected had those soldiers remained in civil life.

As to the changes in war conditions which must be expected in a future conflict, the greatest was that the war strain would no longer be confined to the armed forces but would extend to civilians. He believed that the "blown-ups" and also the "signed-ups" would be increased in number, while the "wind-ups" would

probably be much diminished. It seemed to him that the civilian population, while it might show panic and easily evoked hysterical symptoms, would not require to maintain those symptoms, especially if care were taken to limit all questions of compensation to consideration at the end of hostilities. The increase in the number of "blown-ups" would be due to the effect of long-range artillery—that is, bombing from the air—on buildings and large centres of population. Again, both sexes would be involved, and would include children, adolescents, the middle-aged, and old persons. The "wind-up" group would not have a high incidence such as it had in the great war, for the reason that then the men were away from home, fighting in a land in which they were aliens, with little or no contact with the civil population owing to the difficulties of language. If this country were attacked the people would at any rate be at home, among their own associates and belongings. From such small numbers of the civilian population as one saw in France it seemed that they were singularly free from psychotic or neurotic manifestations in the sense in which he had used the term "wind-up."

The "Fed-up" Group

The "fed-up" group was a distinct danger. The size of this group in the civil population would depend on the duration of the war and the frequency with which urban areas were submitted to bombardment. He would expect the "fed-up" group to appear within three or four months if there was serious interference with sleep and rest. Those who lived in crowded areas liable to attack must, if the war was to be continued for long, be secured moderately frequent rests away from the attacked areas and be able to sleep in safety. It was impossible to imagine workers continuing to put in a ten-hour day in the factories if at night their sleep was liable to be disturbed by fear of air bombing.

Dr. James concluded with a remark about the remote physical after-effects of the late war. Few who served with the fighting troops could be unaware of the tremendous strain imposed. It meant that the generation concerned was likely to be short-lived, and there was some evidence of that among the group of men who were aged from 20 to 40 in 1914, and were active soldiers in the great war, in the present rise in sudden deaths from cardiovascular disease. Thus the casualties of war were by no means over when the armistice was signed.

EMERGENCY TREATMENT OF NEUROTIC STATES

The final lecture of the series was delivered by Dr. J. R. REES, Medical Director of the Tavistock Clinic. He began by pointing out how considerable a problem had to be faced in this field. Some had even said that the psychological casualties as compared with the physical casualties might be in the ratio of three to one. That might seem fantastic, and yet the figures given by Dr. Millais Culpin relating to neurotic symptoms among those working in industry suggested some idea of the largeness of this problem.

Dr. Rees said that he personally learned his first lesson about the handling of civilians under conditions of this kind when he was in charge of the civilian hospital at Ypres. About Christmas, 1914, when shelling started on and around the building, the sisters, who were Belgian nuns, walked round calmly sweeping up the broken glass and laughing with the patients, while the doctors and orderlies got the patients down to the cellar. Those nuns had a calmness in the face of danger that certainly had a therapeutic value for the English doctors and orderlies as well as for the patients themselves. Whether such calmness came from religion or from fatalism, whether it was the result of training or of an inborn sense of duty, it was certainly the first and most essential attitude

for doctors who were leaders and organizers in any group to adopt, because their courage would be communicated to their staff and patients.

The second lesson he learned during the early months of the war was the need of the civilian population for security. The people of Ypres spent their time in caves in the old walls of the city, completely sheltered. Here, despite darkness and vermin, they were cheerful and able to sleep at night, and he believed that the morale of those people who were out working in the day was largely due to the fact that they had security and safety at night. It was most desirable to provide some kind of security for the people they had to look after. Even the semblance of security was better than nothing; if deep shelters or safe cellars could not be provided, sandbags were not without value from this point of view.

Equipment for Emergency

The first-aid shelters should have adequate light and warmth and a liberal supply of the usual offices. Separate rooms would be necessary into which disturbed patients, patients with violent emotional outbursts, should be placed and in which also the doctor could talk to people in private if there was time to do so. It was essential that there should be separate rooms for children, with an intelligent person as nurse, and furnished with toys and children's books and so forth. In those conditions the children would be quiet as they never would be if left with fluttering parents. Dr. James had suggested—and he agreed—that it was a good thing to have the sexes mixed. There was a moral value in keeping together men and women who had the same kind of problems to face. Any attempt at separation of the sexes was to be deprecated. Another element of psychological value would be a gramophone with popular tunes. The effect of music in getting people relaxed and calm was by no means to be despised.

With regard to the things which should be in stock beforehand, he mentioned in the first place the teapot and sugar basin. Alcohol undoubtedly had a part in emergency treatment, and whisky or rum in tea was extremely useful, particularly for people who were in danger of sudden collapse. Food and sweets were important psychologically as well as physiologically. As for drugs, such a mild sedative as bromide and chloral hydrate would help many people of the "wind-up" group. Obvious things like sal volatile and morphine should be included, also he thought nembital and medinal. Dr. James had made the suggestion that the amount of any drug given to a patient should be clearly marked on him, together with the time of administration after the Continental fashion (for example, 15.30).

He was not sure that Dr. James was right in assuming that the anxiety cases would be fewer than the hysterical. In civil life the anxiety cases outnumbered the hysterical by three to one, and in war-time he thought they would have more cases of anxiety to deal with. It was true that cases of gross excitement and of stupor and confusion would be better evacuated and that no attempt should be made to deal with them in the first-aid posts, but the acute anxieties and acute emotional outbursts could be treated then and there. From this point of view the nurses and orderlies should be instructed to encourage people, while waiting perhaps for a medical examination, to get some sort of rest and relaxation. An atmosphere of reassurance should characterize the whole environment. The guiding principle should be to evacuate as few cases as possible. It would be socially disadvantageous if the first-aid posts or clearing stations came to be regarded as a means of getting an easy ride into the country or to a safety zone, and in this case he thought their social duty outweighed their medical. Their work was to get people to return to their homes or duty if at all possible, and only to evacuate those who were so sick that it

would not be safe or wise for them to remain in town or go home.

When they began to take the history of these cases—if they had any chance to do so—they would probably find that many of them were people who had been unstable for years, very likely former patients of a clinic or hospital, and quite unfitted to stand up to the strain of aerial bombardment. But a great many cases would be found in which the method of abreaction would prove of value. It would be useful to get them to talk out the situation. One would suggest to them in the first place that fear was not a thing of which they should be ashamed. The method of persuasion might remove very quickly the conversion hysteria symptom, particularly if it had just begun. The immediate problem, at all events, might be solved in that way.

Suggestion Treatment

The method of persuasion, however, was only for the removal of the symptom; the method of suggestion went more deeply, below the level of consciousness, where the cause lay. Then there were analytical methods of various kinds, which were hardly emergency methods to use in dealing with psychoneurotic breakdown. Peace-time experience showed that the person who had lost himself for the time being or came in mildly confused or dissociated was likely to respond easily to suggestion. It was not necessary to learn the methods of hypnosis—though they were very easy to learn—in order to give the patient a great deal of positive suggestion, directed to his deeper anxieties, and making a fundamental difference in his outlook. Suggestion treatment should aim also at making a man feel that he was one of a group, not separated from it by the fact of these symptoms.

Collective suggestion or hypnosis might well prove of great value, the people being warm and comfortable, and for the moment reassured; in such circumstances it might well be possible to inspire a more confident attitude towards the problems and the difficulties and dangers they had to meet. There was nothing mysterious about the method of suggestion, it was perfectly scientific, those who practised it need not fear the charge of charlatanism, it was a method of reinforcing the positive influences in the patient's outlook.

Having helped some of the people in this way, and sent them back home, it was important to be able to tell them that they could return if they wanted and receive further help. The mere fact that they knew they could return to the same man who had been interested in them meant probably that they would not need to do so. It was a relief to the anxious patient to know that he could return to the same doctor; it enabled him to carry on, it had something like the value of an insurance policy.

The majority of the anxiety cases, he believed, would need to be evacuated, though perhaps not always on the first day. It was worth while to try a little explanation, to give sedatives, and, if at all possible, to get the people back to their homes and jobs. But ultimately the severe anxiety case could not possibly get well within sound of bombs and anti-aircraft guns. The hysterics would be easier, on the whole, to deal with in those conditions.

In conclusion Dr. Rees returned to the point that it was the general attitude of those who treated these people which mattered at least as much as any specific line of therapy they might feel called upon to employ. With some of these patients sedatives would be necessary, with some the abreactive or "psycho-cathartic" method, some would need general treatment, some would require evacuation, but it was the general attitude of doctors, nurses, and orderlies which was so important. It should be sane, calm, cheerful, encouraging. Occupation, again, was one of the best means of prophylaxis against anxiety, and if possible the anxious, frightened, neurotic patient should be given

a sense of adventure in his experiences. That might seem very difficult in the case of the shaking, perspiring "wind-up," but experience had shown that it was not beyond achievement.

The six lectures at the Tavistock Clinic have been attended by large audiences, and many expressions of appreciation of the course were heard at the close.

Reports of Societies

ANOREXIA NERVOSA

A meeting of the Section of Medicine of the Royal Society of Medicine was held on January 24, Dr. H. LETHEBY TIDY presiding, when a discussion took place on anorexia nervosa.

Professor J. A. RYLE spoke of a revival of interest in anorexia nervosa in recent years, accompanying perhaps an increase in the incidence of the disease, but more probably due to its wider recognition and an extended appreciation of the importance of its psycho-somatic relationships. No subsequent descriptions had displaced those of Gull or essentially altered his views on pathogenesis and treatment. Professor Ryle's personal observations included sixty-three private cases, and in these 90 per cent. were in female subjects, most of them girls and unmarried women below the age of 30. The majority of the patients might be classified as psycho-neurotic; some were psychotic. The aetiological factors included emotional disturbances bringing in the affections, slimming in response to teasing, an unhappy home life, overwork and examinations, and convalescence from a physical illness. Perpetuating factors might be a morbid enjoyment of the illness itself or the interest and concern which it created, also lack of a diagnosis and inappropriate treatment resulting therefrom. The condition appeared to occur often among girls sent to finishing schools on the Continent. Among older patients menopausal ill-health more often provided a background for the malady.

The clinical picture of anorexia nervosa included the general effects of starvation with amenorrhoea, slow pulse, low blood pressure, hirsuties, and temperamental changes. The loss of weight might be extreme. The maximum loss in his observed cases was 4 stone, the weight being practically halved. In contrast with these physical findings there was rarely any evidence of anaemia or vitamin deficiency, and there was a degree of activity of mind and body which might have been thought impossible in the presence of such emaciation. The prognosis was very good provided diagnosis was not unduly delayed. Approximately half his own cases did quite well with home treatment. In cases of long standing the treatment was less easy and the prognosis less favourable. Treatment included a full mixed dietary, rest in bed at first, and preferably removal from the parental sphere. He had seen no reason to use insulin or any endocrine preparation, or parenteral vitamin medication, except in those rare cases in which the physical condition was grave and signs of avitaminosis were present.

Contrasting Aetiological Views

Dr. J. H. SHELDON said that the discussion was well timed because there was a considerable ferment of opinion on this subject going on in Continental and American writings, and it was important to try to correlate what appeared to be quite sharply contrasted points of view. The English position lay entirely within the original framework of ideas provided by Sir William Gull; the essential tenet of that tradition was that the loss of appetite or refusal to eat arose in response to what Gull

himself called a morbid mental state. In the speaker's judgment no account of the disease could be even remotely adequate which failed to take into account the mental background that lay behind the clinical features presented by the patient. The English tradition had always regarded those clinical features as being the direct and simple result of starvation. No one had ever posed the question as to how or why it was that starvation produced the results. In roughly one-third to one-half of the reported cases the amenorrhoea arose late in the disease; in others it occurred far too early to be regarded as the result of starvation. It might arise at the same time as the anorexia or even before it. He thought the amenorrhoea in anorexia nervosa where it occurred early might be regarded as an amenorrhoea nervosa. He was satisfied from his own observation that in a proportion of the cases occurring at puberty—somewhere about 30 or 40 per cent.—there was evidence of a previous failure of growth.

The physical features of the established disease must be considered in the light of contemporary American and German literature, in which nowadays cases were misreported under the headings of Simmonds's disease. A number of these observers abroad had rediscovered the disease under various titles, usually attributing it to anterior pituitary insufficiency. The problem of the physical aspects of the disease was to integrate this way of looking at things abroad with the traditional English point of view. Starvation, anorexia nervosa, and Simmonds's disease had a large number of clinical features in common. The best way of explaining this fact appeared to be that the features of starvation were not a series of haphazard peripheral effects, but formed part of a co-ordinated mechanism, possibly hypothalamic, the main feature of which was a diminution of anterior pituitary activity. This made these three conditions simulate each other closely. They differed, however, as to the changes in the hair, where, especially as regards hirsuties, anorexia nervosa closely followed starvation. For the early onset of amenorrhoea in many cases one must postulate a failure of hormone output from the anterior pituitary, due to nervous influences. Anorexia nervosa arose in response to an emotional or mental need. The lowered food intake set in motion a series of changes which were mediated to the body by means of a diminished anterior pituitary activity. This accounted for the general acceptance of these cases abroad as instances of Simmonds's disease.

The Endocrine Aspect

Dr. A. W. SPENCE said that anorexia nervosa presented various problems of interest to the endocrinologist. He did not consider it to be primarily a disease of the endocrine system. The initial disturbance was psychological, the manifestations of endocrine dysfunction being purely secondary. These might be so prominent as to lead to the condition being mistaken for Simmonds's disease. Indeed, he was informed that in Germany the term "anorexia nervosa" was not recognized. In looking through the literature he had found a large number of cases labelled pituitary emaciation which in his opinion would have been more correctly diagnosed as anorexia nervosa. The differentiation between the two conditions rested mainly on the initial psychological factor which was responsible for the loss of appetite. As menstruation was dependent on the delicate balance of ovarian hormones the secretion of which was controlled by the anterior pituitary, amenorrhoea in the presence of a general debilitated condition such as anaemia was necessarily of endocrine origin, but in anorexia nervosa the endocrine origin was not necessarily primary. There was anatomical evidence that nerve fibres passed from centres in the hypothalamus to the pituitary, and it was suggested that the secretion of pituitary hormones was a response to stimuli from those centres. There was no reason why amenorrhoea should not precede anorexia nervosa as a symptom of the disturbance of the higher centres.